Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TEXAS 77289

Respondent Name
CITY OF ODESSA

Carrier's Austin Representative
Box Number 21

MFDR Tracking Number
M4-13-0576-01

MFDR Date Received
October 29, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On May 30, 2012, a Contested Case Hearing was held on June 8, 2012, the hearing office [sic] rendered a final opinion. That opinion noted that the compensable injury of March 29, 2010 did not extend to and include an annular tear in the lumbar at level L5-S1. Through-out this hearing process the claimant was pursuing the additional diagnosis codes and was present at the CCH. The claimant was attempting to get the tear considered a part of the work related injury. However, upon reviewing the 2 codes originally placed on the HCFA by HealthTrust, you will see that the tear was never considered part of the injury by HealthTrust or Dr. Gonzales. It was our employee, HealthTrust employee who failed to include the lumbar sprain/.strain [sic] on our medical records even though the code was originally on Dr. Gonzales' referral script."

Amount in Dispute: $17,226.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bills were denied based on the treatment being rendered for non-compensable conditions. The claimant's original injury was a lumbar strain. The bills that were submitted as treatment were for 4 diagnosis codes: 722.10, 722.0, 726.10 and 847.2. The bills were denied and based on the denial; the claimant pursued an annular tear diagnosis at a Contested Case Hearing". The claimant did not prevail at the Contested Case Hearing. As a result, the provider resubmitted the bills and changed the diagnosis code to the diagnosis code that has been accepted, a lumbar strain. The medical records reflect that the treatment at issue was not for a lumbar strain, but rather for a more complex condition that is not part of the compensable injury."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2011 through August 9, 2011	90801, 90806 and 97799-CP	$17,226.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated
   - RC %P – Based on extent of injury (Note: to be used for Workers' Compensation only)
   - RC 01 – The charge for the procedure exceeds the amount indicated on the fee schedule
   - Comment: Bills are disputed not related to original compensable injury see copy of dispute – not paid under workers comp
   - Comment: Disputing diagnosis not part of original compensable injury
   - RC %0 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - Comments: Preauthorization received 6/2/2011 dates of service prior to 6/2/11; not preauthorized; preauthorization for 1 visit per week x 6 weeks only; disputed claim – please see attached copy of dispute

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability..."

The dates of service in dispute are March 22, 2011 through August 9, 2011. The final decision, inclusive of all appeals, on compensability, extent of injury or liability was issued by the Division on June 8, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 29, 2012. This date is later than 60 days after the date the requestor received the final decision on compensability, extent of injury, or liability. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 4, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.